Postpartum Depression Tool in Burmese Women

A thesis submitted to the University of Arizona College of Medicine -- Phoenix
in partial fulfillment of the requirements for the Degree of Doctor of Medicine

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Class of 2013

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Acknowledgements

I would like to express my deepest appreciate to Dr. Sharry Veres in helping me with this scholarly project. Thank you for your time and patience.

I would like to thank the International Rescue Committee who also helped in this project. Without them, I would not have been able to meet all the wonderful Burmese people.

Lastly, I would like to thank my wonderful Burmese interpreter, Sai. Thank you for walking during the hot summer days in Arizona with me in order to get all the data collection and in helping me get a warm welcome from the Burmese community.

Abstract

Background: In the United States, the prevalence of postpartum depression is 10-15%. There is limited study on the appropriate postpartum screening tool for Burmese refugees in the United States. **Hypothesis:** The Burmese and Karenni versions of Edinburgh Postnatal Depression Scale (EPDS) are appropriate to use as a tool for screening postpartum depression in Burmese refugees. **Aims**: This study examines the views of Burmese refugees on the questions of Edinburgh Postnatal Depression Scale as a routine screening for postnatal depression and their opinion and experiences on postpartum depression. **Methods**: A qualitative approach was chosen to complete this study. A medical student and a Burmese interpreter participated in a one-on-one interview with 30 Burmese women sharing their views and opinions on translated EPDS and postpartum depression. **Results**: Thirty Burmese women were interviewed in the Phoenix area. The qualitative analysis indicate that the EPDS screening turned out to be a useful and culturally appropriate tool for the Burmese refugees to screen postpartum depression in this specific population. **Conclusions**: Without consistent and culturally appropriate screening for Burmese women, it would be hard to treat Burmese women for postpartum depression. Our study shows that acceptability for routine screening with a translated EPDS amongst health visitors is possible to achieve. Using the Edinburgh Postnatal Depression Scale in Burmese and Karenni language should be considered when seeing Burmese refugees in the clinic.

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Introduction

Postpartum depression is a condition that not only affects the mother, but also her baby, significant other, and the rest of her family, which can be long term. Depression can occur within the first month until a year after pregnancy. Postpartum depression worldwide is a growing concern especially if it is not screened properly. Postpartum depression affects women from different cultures. The prevalence of postpartum depression is not significantly different compared to prevalence of depression in non-pregnant women (1). In addition, currently, the prevalence of postpartum depression (PPD) is considered to be 10-15%. Most research studies were completed with a brief one-dimensional instruments (mostly Edinburgh Postnatal Depression Scale—EPDS, images 3-4) with focus on depression and not on their symptoms and disorders (8). Knowing how prevalent it is, it is important that there is a screening tool appropriate for screening postpartum depression in a diverse group of women.

Phoenix is the sixth largest city in the United States for refugee resettlement. There are four refugee resettlement agencies in Phoenix, and the largest agency is the International Rescue Committee (IRC). Refugees will work with the resettlement agency for 6 to 12 months after their arrival in the United States.

Many refugee women seek maternity care in the 6 to 12 months after arrival in the United States, and the Burmese refugees are among these women. This intense immersion into the US health care system can be difficult for the patient, refugee resettlement agency and the clinic providing the care. There are anecdotal reports of these women feeling confused about health care practices and feeling distrustful of medical care, but there has been little formal evaluation of this. There has been one study in Canada that showed Canadian women have less postpartum depression symptoms than immigrant, asylum-seeking, and refugee women. They also report receiving prenatal care and social support (10). Developing culturally appropriate screening tools is important when working with refugees.

Image 3: Original Edinburgh Postnatal Depression Scale

Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: ______________________________ Address: ___________________________

Your Date of Birth: ____________________ ___________________________

Baby's Date of Birth: ___________________ Phone: ___________________________

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:
- ☐ Yes, all the time
- ☒ Yes, most of the time
- ☐ No, not very often
- ☐ No, not at all

This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - ☐ As much as I always could
   - ☐ Not quite so much now
   - ☐ Definitely not so much now
   - ☐ Not at all

2. I have looked forward with enjoyment to things
   - ☐ As much as I ever did
   - ☐ Rather less than I used to
   - ☐ Definitely less than I used to
   - ☐ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - ☐ Yes, most of the time
   - ☐ Yes, some of the time
   - ☐ Not very often
   - ☐ No, never

4. I have been anxious or worried for no good reason
   - ☐ No, not at all
   - ☐ Hardly ever
   - ☐ Yes, sometimes
   - ☐ Yes, very often

*5 I have felt scared or panicky for no very good reason
   - ☐ Yes, quite a lot
   - ☐ Yes, sometimes
   - ☐ No, not much
   - ☐ No, not at all

*6. Things have been getting on top of me
   - ☐ Yes, most of the time I haven't been able to cope at all
   - ☐ Yes, sometimes I haven't been coping as well as usual
   - ☐ No, most of the time I have coped quite well
   - ☐ No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   - ☐ Yes, most of the time
   - ☐ Yes, sometimes
   - ☐ Not very often
   - ☐ No, not at all

*8 I have felt sad or miserable
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Not very often
   - ☐ No, not at all

*9 I have been so unhappy that I have been crying
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Only occasionally
   - ☐ No, never

*10 The thought of harming myself has occurred to me
   - ☐ Yes, quite often
   - ☐ Sometimes
   - ☐ Hardly ever
   - ☐ Never

Administered/Reviewed by ______________________________ Date ___________________________

[1] Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .

[2] Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

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Image 4: Edinburgh Postnatal Depression Scale Scoring

Edinburgh Postnatal Depression Scale[1] (EPDS)

Postpartum depression is the most common complication of childbearing.[2] The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for "perinatal" depression. The EPDS is easy to administer and has proven to be an effective screening tool.

Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt ***during the previous week***. In doubtful cases it may be useful to repeat the tool after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

Women with postpartum depression need not feel alone. They may find useful information on the web sites of the National Women's Health Information Center <www.4women.gov> and from groups such as Postpartum Support International <www.chss.iup.edu/postpartum> and Depression after Delivery <www.depressionafterdelivery.com>.

SCORING

QUESTIONS 1, 2, & 4 (without an *)
Are scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3.

QUESTIONS 3, 5-10 (marked with an *)
Are reverse scored, with the top box scored as a 3 and the bottom box scored as 0.

Maximum score: 30
Possible Depression: 10 or greater
Always look at item 10 (suicidal thoughts)

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Instructions for using the Edinburgh Postnatal Depression Scale:

1. The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days.
2. All the items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others. (Answers come from the mother or pregnant woman.)
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

The Edinburgh Postnatal Depression Scale has been widely used and translated over the world. There have been versions of the EPDS in various languages such as Indonesian, French, Italian, Spanish, Norwegian, Bengali, Arabic, and Aboriginal. These versions have been found to be appropriate screening (4). There is not one formal study done on the appropriate tool for screening Burmese refugees for postpartum depression. To more clearly understand the appropriateness of postpartum depression screening tools for Burmese women, we propose to survey Burmese refugee women about their perception of the translated Edinburgh Postnatal Depression Scale (EPDS) tool and overall understanding and acceptance of the concept of postpartum depression. In one literature review, Asian women's risk factors for postpartum depression include physical/biological, psychological, obstetric/pediatric, socio-demographic, and cultural factors (9). It has been shown in a meta-analysis that the risk factors for postpartum depression include inadequate social support, stressful life events, childcare issues, low income, marital satisfaction, and self esteem. It also showed in a study of Vietnamese, Turkish, and Filipino immigrants in Australia that there is higher incidence of postpartum depression in women over 25 years of age, recent move to the country, little or no English, small amount of friends or family, and physically ill (15).

The purpose of this research is to gain a better understanding of the appropriate tool and screening for postpartum depression in Burmese women. With better screening, Burmese women will be able to get appropriate treatment for postpartum depression.

Research Materials and Methods

This study was conducted after receiving approval from the Institutional Review Board at the University of Arizona. The inclusion criteria were Burmese women who were at least eighteen years of age who were able to communicate via interpreter. Burmese females who are minors were excluded in the study.

Thirty Burmese women who receive assistance at the International Rescue Committee (IRC) in the United States participated in this study. This is sufficient enough in gathering data as a large amount of material does not actually assure transferability, and could end up in a superficial analysis, since it would be harder to test for reflexivity. Fifteen participants would be sufficient. The findings from a qualitative study are not necessarily seen as facts that are applicable to the population at large, but rather as descriptions, themes, or theories pertinent within a specified setting (11).

The data was collected by a one-on-one in person interview conducted with a Burmese and Karenni interpreter staff that took place in their apartments where they live. The interviews were conducted in a private area. A disclosure form explaining the project was provided.

A cover letter was provided in the appropriate language, Burmese and Karenni indicating the purpose of the survey interview and explaining that participation was completely voluntary, that their name and other identifiable information will not be recorded, and that any question can be declined and that the survey could be stopped at any time. Due to the low rate of literacy, the English version of the letter was also translated verbally by the interpreter at the time of survey interview initiation.

The interview was conducted by a medical student from University of Arizona College of Medicine-Phoenix, Chari Belmonte, and with assistance from an interpreter from the International Rescue Committee. The interviews were completed from April 21st 2012 to July 14th 2012. The interpreters from the IRC are trained to handle information with confidentiality. They are the same interpreters used when Burmese refugees are seen by their healthcare providers. No identifiable information such as name or birth date was collected.

Answers to the survey interview were recorded by the interviewer on the paper form and also recorded through an iPAD. Answers were entered into an electronic spreadsheet for analysis.

With the help of the interpreter, the project was described as conducting a survey through an interview one-on-one, to ask the participants questions focused on the postpartum depression tool in order to see if the tool is appropriately translated into their Burmese language and culturally appropriate. The disclosure form was also given which explained the procedure and confidentiality aspect. The participant was given a translated version of the Edinburgh Postnatal Depression Scale (EPDS) (Images 1-2) depending on which language they read, Burmese or Karenni. After reading the EPDS, the participants were asked questions from the survey. The questionnaire, image 5, consisted mainly of open-ended questions for content analysis and some sociodemographic questions, which include highest level of education, language mostly spoken at home, number of pregnancies, and age.

The interviewer wrote responses on the paper form during the interview. Recordings on iPad also application were transcribed for completion. After the interview, the audio-recorded files were transcribed into verbatim reports to make sure that nothing was missed when the interviewer was writing down notes during the interview.

Qualitative analysis was done in light of emerging themes that arose during the interviews. An open inductive analysis was used with interpretation of interview transcripts. Relevant topics and categories were identified with this analysis.

Image 1: Edinburgh Postnatal Depression Scale in Burmese

အယ်ဒင်ဘာရာ မီးဖွားပြီးနောက်ပိုင်း စိတ်ကျမှုစကေး[1] (အီးပီဒီအက်စ် – EPDS)

[1] Cox, J. L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression scale. *British Journal of Psychiatry* 150:782-786

[2] K. L. Wisner, S. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No. 3, July 18, 2002, 194-199

Image 2: Edinburgh Postnatal Depression Scale in Karenni

Karen

Edinburgh Postnatal Depression Scale[1] (EPDS)

[1] Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. *British Journal of Psychiatry* 150:782-786.
[2] K. L. Wisner, B. L. Parry, C. M. Piontek, N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

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Image 5: Interview Questions

Survey Questions

Highest Level of Education: ________________________________
Language Mostly Spoken at Home: ________________________________
Number of pregnancies? ____________________

Is the tool easy to understand? YES NO

Were there any offensive or insulting questions? If yes, which ones?

Were there any questions that did not make sense? If yes, which ones?

What did you think about the tool?

What changes would you recommend for the tool?

Do you recommend this tool for someone who has just given birth?

Have you heard of postpartum depression?

If yes, what do you know about postpartum depression?

Do you know any one who has had postpartum depression?

If yes, was the person treated for postpartum depression?

What does depression mean to you?

Results

Of all the thirty Burmese participants, thirteen finished high school, one finished GED, three finished 9th grade, three finished 5th grade, three completed 3rd grade, and the rest completed either 1st grade, 2nd grade, 7th grade, or 11th grade. Their ages range from 20 to 51 years old. The mean age was 28.6 years old. Majority of the participants speak the Burmese (Chin) dialect while eight of them mainly speak the Karenni dialect. The interpreter and the translated Edinburgh Postnatal Depression Scale (EDPS) were both available in Burmese (Chin) and Karenni dialect. The number of pregnancies for the Burmese participants ranged from none to nine. The mean number of pregnancies for the Burmese women is approximately three, and mode is two pregnancies. The characteristics of interview participants are shown on Table 1.

There were prominent themes in the interviews. First, the Burmese women all agreed that the translated Edinburgh Postnatal Depression Scale was easy to understand. There was one participant who acknowledged that although the translated Edinburgh Postnatal Depression scale was easy to understand, she could not relate much because she does not have any experience with being a mother. She was one of the Burmese women who does not have any children. All the thirty participants did not find the questions on the screening tool offensive or insulting. They also found that the questions all made sense when translated in their own dialect. When the Burmese participants were asked what they thought of the Edinburgh Postnatal Depression scale, there is a common theme that they felt that it does not contradict with their culture, and the tool is appropriate to use for someone who has just given birth: *It is a good tool. Any way a mother could be helped to change something for her after giving birth. We focus on the child. We have a lot of thinking about the child. Mothers feel worried as well as having physical suffering.*

During the interview, the Burmese participants were asked about the changes they would recommend for the EPDS. Many of them asked for bigger font size, as they could not read the characters. This was changed right away after the first batch of interviews. The copies

of the translated EPDS were enlarged and made clearer. After such changes, none of the rest of the participants recommended any other changes for the tool.

When the question on whether the Burmese women would recommend the Edinburgh Postnatal Depression scale to be given to someone who has just given birth, there is a consensus that they would: *Some of women after giving birth do not speak out. They are suffering. It is just good to ask.* One participant did voice out a concern: *Maybe some Burmese women may like it some may not. Some may not understand especially other ethnic people from Karenni. Some are narrow-minded. They may not fully understand what depression means.*

The questionnaire also included questions that explore Burmese participants' knowledge on postpartum depression. Seventeen of the participants have heard of postpartum depression, which is 57%. For those who mostly speak Burmese, it was divided in half on who have heard postpartum depression and who have not. Six Karenni speakers have heard of postpartum depression before which accounts to 75% of the Karenni speakers in the sample. It did show that the high number of pregnancies correlated to more participants hearing about postpartum depression. When looking at highest level of education, eight out of the fifteen the Burmese women who did not finish high school heard of postpartum depression. Nine out of fifteen Burmese women who completed high school heard of postpartum depression. These data are shown on tables 2-5.

For the Burmese women who have heard of postpartum depression, many of them heard different things about postpartum depression. One of the Karenni-speaking woman mentioned: *Mostly I discuss with other friends who have just given birth. They say if it's the first child, they experience postpartum depression.* The common themes in their understanding of postpartum depression is about suffering physically and emotionally and not being able to take care of their household and their children: *Women in our community are expected to do house chores. We cannot do these things after we give birth, so it is hard for us, and we end up feeling depressed.* One of them mentioned symptoms of postpartum depression: *Women with postpartum depression have loss of appetite. They do not want to eat anything. Some of them are feeling sick. Some has dizziness.* Financial difficulties and not having support from family

are also common themes: *Because of having difficulties with money, I felt that contributes to having depression after giving birth. After giving birth, it is hard when we do not have job, and we are trying to survive to feed ourselves. It is difficult, especially back in Burma.*

The study participants were also asked whether they know anyone who has had postpartum depression. Nine of the thirty Burmese women know at least one person who has had postpartum depression. Of these nine women, five of them encountered women with postpartum depression in the refugee camps in Thailand. All five stated that these women were treated while in the refugee camp by doctors with counseling and medications.

The common themes in their perception of meaning of depression are having physical symptoms, financial difficulties, or being alone. For physical symptoms, one mentioned: *When you have depression, you do not feel well, and you do not want to go anywhere or do anything. You cannot sleep or eat.* Three of the participants did not know what depression is while one of them is unable to explain its meaning. One stated that for her*: Depression is only during poverty.* A different perspective is seen from one of the participants: *Loneliness is felt when they are far away from their family and other relatives.*

During this interviews, some of the participants shared experiences of other women or their own by the following quotes: (1) *Women in refugee camps went to the doctors. I've heard after giving birth, women who just gave birth were caught in between fighting of Burmese soldiers and rebels. Some were hurt. I have heard a lot of it.* (2) *It was in Malaysia. We did not have a job or money. We needed to spend a lot for me to give birth. It was very hard. We had a lot to worry. I just met with a doctor once. I was treated only for pregnancy, not for depression.* (3) *After giving birth to my second child, I had to take care of two children at the same time. I could not move well, and I felt depressed at that time. My husband could not help me. Sometimes, I just cried the whole day. I did not discuss this with my doctor.* (4) *One experience in Malaysia, one of my friends gave birth. When she had a baby, her husband was deported back to Burma. She was depressed because the baby did not have a father. When she gave birth, she didn't ask for help. She didn't have anything at all.*

Table 1: Characteristics of interview participants

Characteristic	N
Age	
18-24	7
25-29	15
30-39	4
40-51	4
Language Mostly Spoken at Home	
Burmese (Chin)	22
Karenni	8
Number of Pregnancies	
0	2
1-2	16
3-4	10
6-9	1
Highest Level of Education	
1st grade-2nd grade	2
3rd grade-5th grade	8
7th grade-9th grade	5
10th grade (high school graduate equivalent)	13
11th grade	1
General Equivalency Degree	1

Table 2: Postpartum Depression Awareness

	Have heard of postpartum depression before	Have not heard of postpartum depression
Number of Burmese participants	17	13

Table 3: Postpartum Depression Awareness by Language

Language mostly spoken at home	Have heard of postpartum depression before	Have not heard of postpartum depression
Burmese	11	11
Karenni	6	2

Table 4: Postpartum Depression Awareness by Number of Pregnancies

Number of pregnancies	Have heard of postpartum depression before	Have not heard of postpartum depression
0-2	8	10
$\geq$3	9	3

Table 5: Postpartum Depression Awareness by Level of Education

Highest Level of Education	Have heard of postpartum depression before	Have not heard of postpartum depression
1st-9th grade	8	7
$\geq$10th grade (completed high school)	9	6

Discussion

After the interviews, we found that the Edinburgh Postnatal Depression Scale in Burmese and Karenni language are well received, acceptable, and understandable for the Burmese women. None of the participants felt that it was insulting culturally. Also, the Burmese women reported that they understood the questions well. Therefore, these results suggest that the Edinburgh Postnatal Depression Scale can be utilized in clinic and health centers that see Burmese refugees. To be even more culturally appropriate, healthcare professionals should be able to take into account the social factors the refugees have that influence their conditions during postpartum period (5). With the recommendations that participants mentioned, it is important that the Edinburgh Postnatal Depression Scale is printed clearly in a larger font for easier understanding of the tool.

Our findings suggest that Burmese refugees are not well informed when it comes to mental illness such as postpartum depression or depression in general. In addition, Burmese women have related depression to factors such as financial burden, lack of social support, inability to do household chores, physical symptoms like lack of sleep and loss of appetite, and stressors surrounding them such as being in the refugee camp. The participants' reflections on their own and their friends' experience after giving birth have helped in making them realize the important of getting screened for postpartum depression and being followed up with treatment once needed. Being refugees living away from their native land and away from many of their families and friends, it is even more important that Burmese refugees to be screened for postpartum depression. Despite reports of the effect of postpartum depression in women and their families, it remains that healthcare professionals do not screen or report it frequently (13). Edinburgh Postnatal Depression Scale is available freely, with easy administration for healthcare professionals, and accepted generally if given sympathetically (3). For screening, it is then recommended to use the EPDS in Burmese and Karenni for Burmese refugees.

For strengths of this study, having thirty as the number of participants is sufficient for this qualitative type of study. A large number of participants between thirty and sixty would be needed to obtain richness of data for qualitative analysis (12). For limitations, the participants were only from around the Phoenix area. Also, there could be two different studies between

the two different languages that are mostly used, Burmese and Karenni. There are many other cities with Burmese refugees aside from Phoenix. Another limitation is with the interpreter. Having one interpreter is also a limitation as it is hard to measure the interpreter's accuracy. It is also important to address that there are questions left unanswered after completing this study. For example, in participants who learned about postpartum depression, what were their sources? Also, for those who completed their schooling, did they get educated on postpartum depression? For those who reported having postpartum depression before, how was the experience like? How long did they have postpartum depression? These are questions that need to be answered if given a chance.

Future Directions

After completing this study, there are more opportunities as well as needs for developing culturally appropriate materials for different cultures in screening for health disorders such as postpartum depression. With current studies available, postpartum depression research has been mainly on population as a whole as there are many studies on refugees and immigrants (5). For Burmese refugees, it is important to use Burmese and Karenni version of Edinburgh Postnatal Depression Scale in clinics for screening. Once this is in place, this could lead to more research opportunities in obtaining the prevalence of postpartum depression in Burmese refugees. With proper screening, appropriate treatment for Burmese women who have postpartum depression can also be studied. Also, after finding out that many of the Burmese women do not have an understanding of depression, this opens an opportunity for education in the community setting for the refugees' awareness of mental illness. With more awareness, then there would be more chance that they seek help from healthcare professionals when in need.

Conclusions

Without consistent and culturally appropriate screening for Burmese women, it would be hard to treat Burmese women for postpartum depression. Our study shows that acceptability for routine screening with a translated Edinburgh Postnatal Depression Scale amongst Burmese refugees is possible to achieve. Using the Edinburgh Postnatal Depression Scale in Burmese and Karenni language should be considered when seeing Burmese refugees in the clinic. Also, education of Burmese refugees on depression and other mental illnesses is imperative in bringing awareness for their population. Starting with proper screening, things can lead to better treatment and prevention of postpartum depression among the Burmese population in the United States.

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